Correspondence

The Editors will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words and must be typewritten, double-spaced, and submitted in duplicate (the original typescript and one copy). Authors will be given the opportunity to review the editing of their correspondence before publication.

Health Problems in the Chinese in North America

To THE EDITOR: There are about 780,000 persons of Chinese lineage living in the ten states for which this publication is the official medical journal. Most are from the southern Chinese province of Guangdung. Its capital is Guangzhou, formerly Canton; hence, the name Cantonese has been used broadly to include all those from this province. A sizable number of ethnic Chinese have come by way of familial sojourns in various Southeast Asian nations such as Vietnam. More recent immigrants have come from Hong Kong, Taiwan, and now all parts of China. Of the 1.65 million Chinese Americans in the United States, most are American-born.

As the population of persons of Chinese descent continues its dramatic growth in the western United States, these few observations on their health predispositions may prove useful.

One of the major hematologic problems is the thalassemia syndromes. Obvious hemolysis is less of a problem than microcytic, hypochromic Wintrobe indices, either with or without mild anemia. Iron content may need to be evaluated, and genetic counseling may be appropriate. Hyperthyroidism is common, and muscle weakness is more frequent than in the general population.[1] Intestinal lactase deficiency is so ordinary that many patients learn to drink milk to avoid constipation. Colon cancer is the most frequent malignant neoplasm at Chinese Hospital.[2] While nasopharyngeal carcinoma is of lower prevalence, it strikes Chinese men more often than it does most other ethnic groups.[3] Its effect was sufficient to convince the venerable Dr Francis Sooy once to recommend empiric biopsy in any young Chinese man with nasopharyngeal symptoms slow to resolve. Distracting pruritus occurs early in life among southern Chinese due to cutaneous senescence that is premature compared with other ethnic groups. It is manifested early as dry skin (xerodermatosis) and crosses over into psoriasis and atopic dermatitis. The eyeball is longer in the anteroposterior axis, which frequently causes myopia and retinal detachment.

Although hepatitis B and tuberculosis are not unique to the Chinese population, the high incidence of these infections must always be kept in mind when dealing with these patients. It was apparently hepatitis B that led to the high incidence of hepatocellular carcinoma among the Chinese, just as the rarity of placental carcinomas among Asian women in the United States, contrasting with its high incidence in parts of the Far East, also suggests environmental factors.[4]

Of important therapeutic implication is the relatively faster acetylation rate seen among Chinese compared with other racial groups for drugs such as procainamide, isoniazide, and hydralazine. Lupus reactions seem to be uncommon, thus removing this potentially toxic limitation on the use of these agents.

Curiously, despite the old clinical saw that all cases of Huntington's chorea in the United States can be traced to one family, there is living in San Francisco a family from Guangdung with this neurologic disorder.

Hypertension is common with all its usual complications but is far less serious than in African Americans. Diabetes mellitus appears to be less frequent in the Chinese than in the rest of the American population.[5] Coronary artery disease is shifting its façade from ischemic cardiomyopathy among elderly Chinese to angina pectoris or myocardial infarction syndromes in the younger population. In Shanghai, serial studies have shown a progressive rise in mean serum cholesterol levels as that populace has become more westernized.

Certain customs may confuse American clinicians. Chinese girls from some districts of Guangdung use their fingers to pinch lower paratracheal subcutaneous fat to fill out the space between the trachea and the sternocleidomastoids bilaterally. Over the years, this practice creates a "pseudogoiter" that may nonetheless be hiding genuine thyromegaly. For sickness, moxibustion, a practice of burning herbal leaves on the skin, might be used. For pain, hard metallic objects such as tablespoons might be employed to forcibly scrape the skin to draw off noxious substances. These practices leave behind burns or ecchymoses that immediately conjure up visions of bizarre disease or elder abuse in the minds of unwary clinicians.

These are examples of observations that vary in scientific foundation. Better substantiation is needed, but interest and funding are inadequate. Research into diseases of high incidence provides larger pools of scientific data; research into diseases of low incidence may clarify pathogenicity when comparative population studies are done. Further research into these health predispositions in the Chinese-American population would thus be of distinct benefit to the general population whether the focus is on a disease of high or of low incidence.

To help give direction in addressing these ethnic issues, the Chinese Hospital medical staff began a biennial conference on health problems related to the Chinese in North America. In 1992 it will be held at the Sheraton Palace Hotel in San Francisco between June 18 and 21. Topics covered include medical science, nursing, optometry, health care delivery, and traditional Chinese medicine. Inquiries should be directed to the Medical Staff Office, Chinese Hospital, 845 Jackson St, San Francisco, CA 94133-4899, (415) 677-2480.

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More On the 'Gag Rule'

TO THE EDITOR: I hesitated to respond to Dr Laura Hammons's letter in the December 1991 issue[1] because so much has been written about the abortion issue with so little effect. Her letter was so irrational and misguided, however, that I finally had to respond.

Her contention is that the "gag rule" prohibiting physicians from discussion of abortion is only a monetary issue. Medi-Cal (California's medicaid program) pays $206 for an abortion. In contrast, prenatal care is reimbursed at $961, and, for a normal delivery, newborn care is $566. If the infant has drug withdrawal, is infected with the human immunodeficiency virus, or is premature, the cost of care is $4,509. The welfare payment for one person is $326 per month and for a family of two is $535. In addition, the mother will probably get supplemental food vouchers, and the child will receive Medi-Cal coverage for ongoing medical expenses. Every birth costs the taxpayers many times the cost of an abortion, so if the question of morality is not important, Dr Hammons should be an abortion advocate.

She objects to her taxes going to support abortions, referral for abortion, or abortion counseling for poor women who voluntarily request them, but we all have objections to some of the things our taxes pay for, such as military equipment that does not work, tobacco subsidies, and photo-opportunity-rich, policy-poor political junkets.

The issue is a matter of free speech. When speech is restricted by application of a penalty based on the content of the speech, it is not free. This particular speech is part and parcel of medical practice. It is not political speech or opposition to or advocacy for some governmental policy. Physicians are not prohibited from the latter, only from discussing medical options, one on one, with their patients. Drs Sugarman and Powers have provided an excellent analysis of the constitutional issues involved.[2]

Obviously, if our only concern were rational, secular, good public policy, we should all be promoting family planning and abortion to control the population that is outstripping our resources. This leads me to believe that the opponents of free speech, good medical practice, and safe abortions have a different rationale, namely, a set of moral values that they want to impose by governmental power on all of us.

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Treating Status Epilepticus

TO THE EDITOR: In the otherwise excellent review of status epilepticus by Dr Watson,[1] the management outline presented does not follow traditional or practical resuscitation protocols. First, the initial management should consist of securing the ABCs (airway, breathing, circulation), which includes ensuring that the airway is patent and that adequate air exchange is occurring. Nothing, including oral airways, should be forced into the mouth. Although flexible nasal trumpets may be helpful, their use should be balanced by the risk of increasing intracranial pressure, and they are contraindicated in patients with facial trauma. Endotracheal intubation is frequently necessary. Because the teeth are often clenched and nasotracheal intubation is relatively contraindicated because of the possibility of increases in intracranial pressure, orotracheal intubation should be done after "crash" anesthetic induction with thiopental sodium and the short-acting paralytic agent succinylcholine chloride if there is no contraindication. An added advantage to thiopental is that it may stop the seizures for a short time by itself and often is sufficient to loosen the clenched teeth without using paralytic agents. During this period special attention to cervical spine control is paramount because trauma, either before or after onset of the seizure activity, may have caused injury to the cervical spine.

While the airway is being secured, rapid intravenous (IV) access should also be obtained. Rather than routinely giving 25 grams of glucose, though, it seems pertinent to measure fingerstick blood glucose from blood drawn at the time of the IV insertion. This takes approximately a minute. I agree that 100 mg of thiamine hydrochloride should be given, but it does not have to precede glucose administration as implied. Therapy for documented hypoglycemia always takes precedence over the theoretical risk of producing Wernicke's encephalopathy—which is not likely to occur over minutes anyway.

Finally, how does administering 20 mg per kg of phenytoin sodium in an average-sized adult (60 to 80 kg) at 25 mg per minute equate to 20 to 40 minutes? By my arithmetic, it should take between 48 and 64 minutes. Since 60 minutes appears to be the critical outside limit for the duration of tonic-clonic status epilepticus, and it usually takes more than a few minutes to get to the hospital, secure the ABCs, mix medications, administer lorazepam, and so forth, why not go directly to the faster-acting barbiturates if benzodiazepines fail? As long as someone who can manage an airway is present, it seems impractical and perhaps dangerous not to stop the seizures as quickly as possible. Phenytoin, which has not been shown to be very efficacious in status epilepticus or seizures due to any cause other than idiopathic epilepsy, can then be given after or coincidentally with phenobarbital if desired.

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REFERENCE

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Dr Watson Responds

TO THE EDITOR: I appreciate Dr Wrenn's comments and interest in my review article on status epilepticus.[1] I have no quarrel whatsoever with his comments concerning the initial evaluation and management of the patient presenting to the